COMMERCIAL MARKET STRATEGIES
NEW DIRECTIONS IN REPRODUCTIVE HEALTH

Engaging the Private Sector in Turkey

CAN PUBLIC/PRIVATE PARTNERSHIPS HELP ACHIEVE CONTRACEPTIVE SECURITY?

Prepared by: Françoise Armand
Cindi Cisek
April 24, 2002

OCCASIONAL PAPER SERIES

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CMS's Occasional Paper Series was developed to inform USAID on crosscutting themes and developments on the private sector's role in reproductive health and family planning. Occasional Papers in the series may also discuss health impact, and specific CMS research and country program operations. All papers in the series have been reviewed by relevant CMS technical leaders and by CMS program management staff.

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The cover photograph for this study is a photo taken from "Berdel", an award-winning film produced by the Turkish Family Health and Planning Foundation in 1990. The Foundation has been a key partner in social marketing interventions funded by USAID and continues to be a major contributor to the advancement of family planning in Turkey.

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Acronyms

CMS	Commercial Market Strategies
DHS	Demographic and Health Survey
FP	Family planning
IUD	Intra-uterine device
KAP	Kadin Sagligi Ve Aile Planlamasi Hizmet Sistemi (Women's Health and Family Planning Service System)
MOH	Ministry of Health
OC	Oral contraceptive
RH	Reproductive health
SOMARC	Social Marketing for Change
TFHP	Turkish Family Health and Planning Foundation
USAID	United States Agency for International Development

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Summary

The Contraceptive Supply Challenge in Turkey

From 1988 to 2002, USAID supported a number of initiatives designed to increase the provision of contraceptive methods through the private sector. These initiatives included social marketing programs through the Social Marketing for Change (SOMARC) project and public/private workshops on contraceptive self-reliance through the POLICY project. The purpose of this case study is to document the impact of partnerships with the private sector beyond graduation from donor funding. The lessons learned in Turkey are expected to help design interventions that can maximize both financial sustainability and long-term impact, two necessary conditions for achieving contraceptive security.

Social Marketing Interventions

The condom, pill, and injectable markets evolved in different ways after donor funding for social marketing projects ended. The most impressive changes occurred in the *condom market*, which was still dynamic and growing in late 2001. Social marketing activities supported by SOMARC from 1990 to 1993 contributed significantly to this growth. The combined efforts of a local non-governmental organization, SOMARC's commercial partner, and the Durex Company resulted in the near doubling of the condom market in 10 years, with the condom brand created by the social marketing program (OK) accounting for 52 percent of total sales.

The *oral contraceptive* (OC) market changed less dramatically, in spite of a permanent shift in demand from high- to low-dose pills and new product launches by manufacturers. Market size did not grow significantly after the phase-out of the social marketing program in 1994, but overall sales followed a gradual upward trend. Pill manufacturers still faced substantial legal obstacles (such as price controls and advertising restrictions) that discouraged private sector investment in this class of products.

Injectable contraceptives were launched for the first time in the private sector in 1997, just before the end of the SOMARC program. This method received less support than condoms or oral contraceptives and efforts to expand the injectable market have had limited results. Because injectables face unique challenges in new markets, promoting better acceptance of this method in Turkey required substantial funding and sustained commitment from manufacturers. Unfortunately, the combination of low margins and low sales volumes kept private sector investment minimal after the SOMARC phase-out.

SOMARC experimented with *services marketing* in 1995 with the KAPS provider network. This program showed good potential and might have produced measurable results, given more time and money. Promoting family planning

services as a way to attract new clients, however, may not have been the best strategy. The network successfully experimented with post-abortion counseling toward the end of the program, but was unable to sustain other network marketing and management activities beyond the life of the project. Although the network is no longer in existence, former members appear to have permanently integrated family planning and post-abortion counseling in their patient services.

Policy Interventions

The POLICY project helped convince the Ministry of Health (MOH) that it could not continue to provide free contraceptives for all. Faced with the phase-out of USAID donations, the MOH agreed to develop a strategy that would target scarce public resources to those who need it the most. In addition, the MOH pilot-tested a cost-recovery mechanism that may allow the MOH to recover some contraceptive procurement costs and have the added effect of directing people who can afford it to the private sector

The private and public sectors, however, have not found sufficient common ground to cooperate on issues of contraceptive security. Though the MOH, through the POLICY project, attempted to engage the private sector in contraceptive security policy dialogue, market constraints still discouraged significant commitment by private companies. In addition, longstanding philosophical and practical obstacles continued to prevent the development of a coordinated strategy.

Lessons learned

The case study developed by CMS analyzes the factors that influenced the long-term impact of these partnerships with the private sector. Key lessons listed at the end of this brief include the following:

The long-term impact of partnerships with the private sector is largely determined by their compatibility with the goals of partnering organizations. While past interventions may have been justifiably focused on financial sustainability and graduation from donor funding, closer attention to the long-term interests of partnering organizations might have increased the impact of social marketing interventions on contraceptive security.

Using FP services to increase client volume at private sector facilities is unlikely to be effective unless significant potential demand exists for these services. Attempting to increase client load at private sector facilities by promoting family planning services had limited impact because little demand existed for those services. In contrast, both demand and supply increased when the KAPS network focused its efforts on post abortion clients. Some respondents suggested that increasing client load demanded focusing on the quality of primary care services, which were in higher demand among the mainstream population.

Creating long-term demand for new methods requires sustained marketing efforts focusing on both consumers and providers. A combination of low margins and low sales volumes contributed to making injectables unprofitable for manufacturers. As a result, the intensive marketing efforts needed to promote this new method could not be sustained after the end of the SOMARC program. A long-term strategy for new methods requires reaching a compromise between affordable prices and the margins needed to sustain demand creation investment beyond graduation from donor funding.

Unfavorable policies toward the private sector can undermine the impact of social marketing partnerships. This is especially true for pharmaceutical products. Price controls, advertising restrictions and indiscriminate distribution of free contraceptives through the public sector all contributed to discouraging private sector investment. Though the POLICY project introduced the idea of targeting subsidies to the neediest, more efforts may have been needed to improve the context in which contraceptive manufacturers operate.

Partnerships with the Private Sector can help increase contraceptive security; this role can be maximized through better coordination with policy activities. A common goal of ensuring contraceptive security is needed for policy and social marketing activities to complement each other. Future projects involving the private sector might want to address policy barriers within their scope of intervention and/or coordinate with projects that work with the public sector.

Introduction

Turkey is a country with many contrasts: It is the world's 17th most industrialized nation, yet it ranked only 86th out of 180 countries on the 1999 United Nations Development Program Human Development Index. It has a strong and rapidly growing private sector, but the state still plays a major role in the country's economy. Despite its open support of women's reproductive health rights (including abortion) less than 40 percent of married women use modern contraceptive methods - a figure lower than that of many developing countries.

Until 1980, Turkey's economy was insulated and state-directed. In the 1980s, however, the country began an economic turnaround based on an increased reliance on market forces, export-led development, and integration with the world economy. These reforms brought Turkey impressive benefits and average annual growth rates that surpassed all other OECD[1] countries throughout most of the 1990s. They also unleashed Turkey's dynamic private sector and allowed it to become the engine of economic development. The country experienced a financial crisis in late 2000, which prompted the government to commit to additional economic reforms.

The dynamism of the private sector is one of several factors generating optimism about the Turkish economy in the medium to long term. Other reasons include a young population; a location at the crossroads of Europe, Central Asia, and the Middle East; a skilled labor force; and trade agreements with the European Union. With a per capita gross national product of $3,000 per year, Turkey has been classified by the United States Agency for International Development (USAID) as a middle-income country.

Turkey received assistance from USAID for several decades. Although the USAID Mission closed in 1976, the agency continued population assistance through the centrally funded Office of Population. USAID was the sole provider of contraceptive commodities to the Turkish government until a phase-out plan was announced in 1994. Between 1995 and 2002, USAID focused on supporting programs that would contribute to long-term sustainability in family planning and reproductive health (FP/RH). The concept of *self-reliance* in procuring commodities became a key concern for the agency and led to unprecedented efforts to achieve cooperation between the public and private sectors.

The purpose of this case study is to document the impact of USAID-supported interventions on the provision of family planning products and services in the private sector between 1991 and 2001. In addition, we hope that some of the lessons learned from these early partnership programs can help address today's contraceptive security challenge in countries that are facing donor phase-outs.

Photo provided by The Turkish Embassy in Washington, D.C.

Turkey is a country of many contrasts, but its dynamic private sector, young population and skilled labor force are among the factors generating optimism about the country's economic outlook.

1 *Organization for Economic Cooperation and Development*

Family Planning in Turkey

Contraceptive Use

The rate of population growth in Turkey slowed considerably between 1978 and 1998 and was estimated at 2.6 percent in 1998, although important differences existed between regions. Overall contraceptive use among married women had increased sharply from 1978 to 1988 (38 to 63 percent), but then leveled off for the next 10 years. In spite of a significant shift from traditional to modern methods of contraception, withdrawal remained the most commonly used method for almost one-fourth of all couples.

The 1998 Turkish Demographic and Health Survey (DHS) indicated that one in five married women reported using an intra-uterine device (IUD), 8 percent used condoms, and less than 5 percent used OCs. Injectable contraceptives had just been introduced and were used by only 0.5 percent of married women. The survey also revealed marked differences according to residence, socio-economic background, and education. In particular, urban women with higher education were much more likely to use a modern method than rural women were. Changes between 1988 and 1998 were predominantly in the composition of methods used: The proportion of women using IUDs and female sterilization increased while that of women using the pill actually declined.

Table 1:
Percentage Distribution of Married Women by Contraceptive Methods Used[2]

	1988	1993	93/88	1998	%98/88
Any method	63.4	62.6	-8.0	63.9	+1.3
Any modern method	31.0	34.5	+3.5	37.7	+3.2
Pill	6.2	4.9	-1.3	4.4	-0.5
IUD	14.0	18.8	+4.8	19.0	+0.2
Condom	7.2	6.6	-0.6	8.2	+1.6
Female sterilization	1.7	2.9	+1.2	4.2	+1.3
Other modern methods	1.6	1.3	-0.3	1.1*	-0.2
Any traditional method	32.4	28.1	-4.3	25.5	-2.6

* Includes injectables, which were launched in the public and private sectors in 1997 and 1998.

Contraceptive Supply

In 1965 contraception was legalized in Turkey. From 1965 to the early 1990s, an egalitarian mindset dominated most policy discussions, so that efforts to identify priority groups within the Turkish population were broadly interpreted as contrary to constitutional law. The Ministry of Health (MOH) assumed the responsibility of providing FP products and services at no charge to all Turkish

2 *Source: 1988, 1993 and 1998 Turkey Demographic and Health Surveys*

men and women, regardless of social class or ability to pay. Services and products were made available at public facilities (including family planning clinics, hospitals, and primary health care facilities) and, on a more limited basis, through the country's largest social security organization: Sosyal Sigortalar Kurumu (SSK). MOH facilities offered IUDs, pills, condoms, and surgical sterilization for men and women. The public sector FP program relied entirely on donated contraceptives from USAID until 1994, when the government of Turkey and USAID jointly announced an agreement to phase-out contraceptive donations within five years.

The private sector also contributed to the development of FP in Turkey. While services and products became widely available in the commercial sector, several not-for-profit organizations worked on promoting FP and modern contraceptive methods. In spite of the widespread availability of contraceptive methods and services in the private sector, the general trend between 1988 and 1998 was an increase in the percentage of women who obtained their contraceptives (particularly IUDs) through the public sector. The bigger jump from private to public sector supply sources occurred between 1988 and1993, which raised the concern that the Turkish MOH might face difficulties in meeting the growing demand for products and services. This trend then slowed down considerably between 1993 and 1998 and in the case of condoms, reversed itself.

Table 2:
Percentage of Women Using Contraceptive Methods Who obtain them from the Public Sector[3]

Method	1988	1993	%93/88	1998	%98/88
Condoms	25.4	28.7	+3.3%	27.7	-1.0
Pills	14.9	24.2	+9.3	26.0	+1.8
IUDs	53.0	70.9	+17.9	71.0	+1.0

USAID Assistance Programs

Throughout the 1980s and 1990s, several cooperating agencies worked on ensuring supply and creating demand for modern contraceptive methods, as well as providing extensive technical assistance to the MOH in service delivery and training. USAID commodity donations to the Turkish government helped ensure the availability of contraceptive methods at MOH facilities around the country. In addition, USAID also supported several social marketing interventions under the SOMARC project's umbrella between 1988 and 1998. These interventions aimed to increase consumer demand for FP and improve the supply of contraceptive products and services through the private sector.

Unanticipated budget reductions at USAID in 1999 led to the phase out of population assistance earlier than planned. A three-year strategy was developed to achieve a smooth phase-out of the program by the end of 2001. As USAID

3 Source: 1988, 1993 and 1998 Turkey DHS

prepared to leave Turkey, five cooperative agencies were ending their activities, which focused on building local capacity in various areas of reproductive health. One of them, the POLICY project, helped the MOH manage the phase-out of contraceptive donations and prepare for full self-reliance by March 2001.

The Contraceptive Self-Reliance Project (1995 to 2002)

Helping the Turkish government meet the population's contraceptive needs independent of donor assistance became a key objective for the USAID mission. In 1995, USAID and the MOH initiated work on the Self-Reliance Project, with technical assistance from the OPTIONS II and POLICY projects.

The purpose of the CSR project was to transfer the responsibility of the funding and management of contraceptives from USAID to the GOT. This transition process took place gradually over a period of seven years. One of the basic principles underpinning the CSR project was that self-reliance in the national FP program could be attained only through the active participation of all sectors. Private sector involvement was highly desirable at two levels: to supply low-cost contraceptives to the MOH through procurement tenders, and to actively market modern contraceptive methods in commercial outlets.

In 1996, the POLICY project conducted a secondary analysis of the latest available DHS that "segmented" potential contraceptive users according to their risk levels and contraceptive procurement patterns. This analysis revealed that high-risk groups (such as women with low-income levels and low health insurance coverage) presented the highest unmet need. Yet, the public sector was using a considerable amount of its resources to subsidize long-term method users who were able to pay for those services. One of the conclusions of the segmentation analysis was that these users should be served by the private sector and that subsidies should be targeted to the neediest.

With support from the POLICY project, the MOH conducted a public-private partnership workshop in May 1997 that brought together key players from the public, NGO, and commercial sectors. This workshop was welcomed by the private sector and heralded as the first time that such dialogue had occurred. The meeting's main outcome was to focus public sector resources on high-risk groups, thereby introducing the idea of targeting in the public sector strategy. The private sector was encouraged to contribute to the achievement of national population program goals by improving service quality to attract clients who could pay.

Key Results

The procurement of contraceptives by the MOH implied issuing tenders that manufacturers with a presence in Turkey could compete for. Between 1997 and 2001, the MOH successfully completed several large contraceptive tenders, but

not without some difficulties, particularly in the area of currency management and planning. Because the MOH was only able to complete three out of ten centrally planned tenders, some of the procurement process had to be assumed by regional MOH facilities. Small, decentralized tenders were neither cost-effective for the government nor profitable for manufacturers. As a result, this area of the procurement process still needed improvement at the time of the assessment.

The conclusions of the public/private workshop led the MOH to experiment with a cost-recovery mechanism involving voluntary contributions in three provinces. At the end of the pilot project, 60 percent of users had made donations and 40 percent had declined. Demand for condoms and OCs – but not IUDs – decreased at public health centers that implemented the donation policy and it was assumed that a number of users had switched to a private sector source. Six months after the pilot study, the MOH officially adopted a targeting strategy that allowed for cost-recovery at public health facilities. According to this plan, poor clients would continue to receive contraceptives at no charge while others would be asked to contribute to the cost of these products. Donations for contraceptives were expected to fund approximately 38 percent of the MOH's contraceptive needs once the strategy was implemented in 30 provinces.

Impact on the Private sector

Despite the emphasis placed on private sector participation during the 1997 workshop, few concrete steps were taken to promote it. In late 2001, there was still skepticism and confusion in the public sector about the role of the private sector. The MOH wished for more active participation by the private sector in contraceptive tenders, demand-creation activities, training support for new products, and provision of postpartum and post-abortion services. Key respondents at the MOH acknowledged the value of private sector initiatives, such as the condom and pill social marketing projects, but felt that they had no impact beyond urban areas and that more should be done to serve high-risk groups.

In contrast, pill and injectable manufacturers felt that their role should be to focus on increasing their existing core consumer group, which is typically made of upper-income, educated women living in urban areas. They expressed frustration at what they perceived to be the lack of a clear national policy on RH and felt that the MOH was not supportive of the private sector, particularly in its price control policies. In addition, frequent personnel changes and conflicting agendas in the government also proved discouraging for pharmaceutical companies, though they continued to express interest in cooperating with the MOH.

All three pill manufacturers considered bidding for tenders issued by the MOH for the procurement of OCs, but concluded that it was not in their interest to develop this business, considering the meager margins allowed on tender contracts. Moreover, some manufacturers opposed the distribution of free contraceptives in public facilities as they discourage women from

purchasing commercial brands in the commercial sector. This unwillingness to bid for government contracts threatened to disrupt future procurement plans by the MOH.

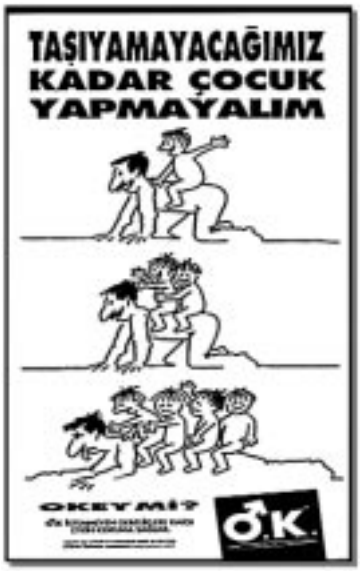
A weakness of the CSR project seems to have been the absence of continued collaboration with the private sector. This shortcoming can be explained by the project's focus on developing management and procurement capacity at the MOH. Nevertheless, despite the lack of explicit cooperation between the two sectors, it seemed likely that the targeting strategy adopted by the MOH would result in an increase in women seeking FP services in the private sector.

Social Marketing Interventions (1988 to 1998)

The basic goal of the SOMARC project in Turkey was to increase the provision of modern FP methods through the private sector. In 1988, SOMARC conducted an initial assessment of the Turkish contraceptive market and recommended a social marketing intervention that would include condoms and OCs. The project proposed to leverage Turkey's well-developed private sector infrastructure through partnerships with prominent pharmaceutical manufacturers.

Because eventual graduation from donor funding was a key aspect of the project's design, partnering with a local organization that could take on a leadership role was considered critical. This organization turned out to be the Turkish Family Health and Planning Foundation (TFHPF) – a private, non-profit organization established in the mid-1980s by one of Turkey's most established businessmen. The Foundation's Board of Directors, which was composed of representatives from several major Turkish corporations, proved instrumental in enlisting private sector support for SOMARC-led activities. In addition, the Foundation's lobbying skills allowed the project to advertise branded condoms for the first time.

The project also sought to identify private sector partners that could provide strong marketing and distribution support to the project. For condoms, the project partnered with Eczacibasi, a local pharmaceutical manufacturer and distributor with an impressive product portfolio and marketing capacity. For OCs and injectables, SOMARC partnered with four manufacturers (Schering, Wyeth, Organon, and Pharmacia & Upjohn), whose combined sales represented over 90 percent of the pharmaceutical contraceptive market in Turkey.



This promotional poster for OK condoms says, "Don't have so many children that you cannot carry them – OK?"

The Condom Project

The initial assessment conducted by SOMARC revealed a limited commercial market with few brands, poor product visibility, and negative attitudes towards condoms. Attempts by SOMARC to partner with the international condom manufacturer Durex to expand product availability in Turkey were unsuccessful. SOMARC eventually partnered with Eczacibasi to launch a new condom brand

after a market study conducted by the pharmaceutical company revealed good sales and profit potential in the condom market.

In June 1991, Eczacibasi launched *OK* condoms. From the onset of the project, SOMARC and its partners worked towards product self-sufficiency and graduation from USAID funding. Eczacibasi was the first commercial sector partner to fund commodity costs for a contraceptive social marketing project. The company also agreed to contribute a percentage of sales revenues to TFHPF, which was given ownership of the new condom brand. USAID funding was used to finance demand-creation activities such as mass media advertising.

The project partners developed a brand with a clean, high-quality image, in hopes of positioning condoms as a respectable and reliable FP method. Following successful lobbying by TFHPF for the right to broadcast branded condom advertising, Eczacibasi released a clever but conservative TV campaign that featured a young Turkish couple discussing safe sex without ever mentioning the word condom. The TV spot won Turkey's Crystal Apple Award in 1992-1993, and the Population Institute Award in 1994. Eczacibasi also used classic consumer goods promotional tactics to popularize condoms, such as outfitting Turkey's national soccer team with new uniforms bearing the *OK* logo.

This magazine advertisement for OK condoms claims "Double Protection".

While *OK* condoms were priced within the lowest tier of the condom market, this price was enough to cover procurement costs and a profit margin. It is important to note that Eczacibasi adamantly refused to make *OK* the cheapest condom brand on the market, in spite of strong pressure from USAID. The company successfully argued that a price too low would make it impossible to sustain the brand beyond graduation. By the time the project graduated from USAID support in December 1993, the price of *OK* condoms had been increased fivefold to keep up with inflation, but remained in the same price point category- between the most expensive brands (*Amor* and *Durex*) and the least expensive brands (*Jellia* and *Beybi*). In the end, the project succeeded in capturing its intended target group: 68.5% of *OK* brand users were found to belong to the C, D and E socioeconomic groups[4].

Key Results

In the first two years of the project, *OK* outperformed expectations. Eczacibasi sold 4.5 million condoms in 1991 and 5.9 million in 1992, exceeding sales targets by 28 percent and 18 percent respectively. By 1992, 70 percent of all outlets selling condoms were carrying *OK*. Eczacibasi also successfully expanded condom distribution beyond pharmacies, introducing them into supermarkets, small convenience stores, and drug shops. In mid-1992, the distributor launched *OK Extra* (with spermicide), a line extension product that also contributed to the return-to-project fund for TFHPF.

The *OK* communication campaign appeared to meet its goal of destigmatizing condoms: A tracking survey conducted by SOMARC in 1992 revealed that 75

4 Source: TCCM Project Advertising Tracking Survey. TFHPF and Zet Medya research, Inc. (November 1992)

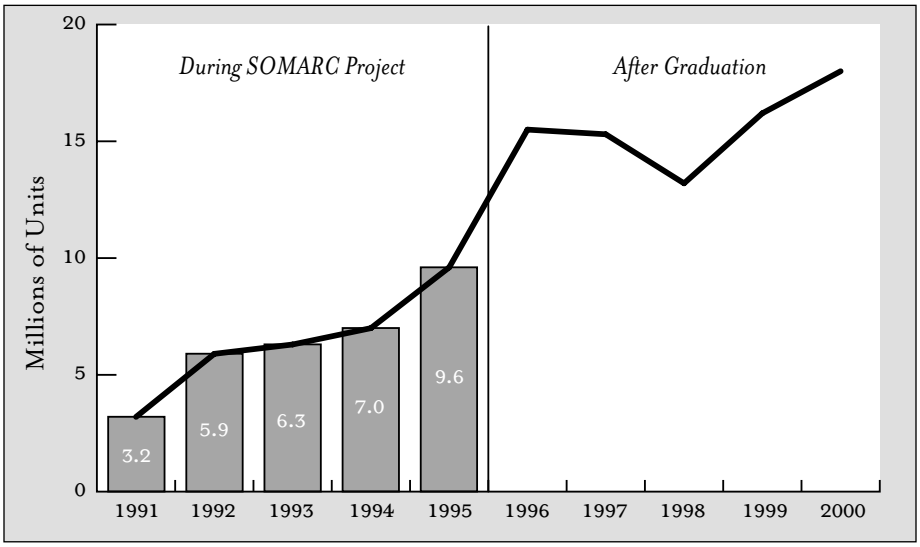
percent of married men and women approved of condom advertising on television and radio. Sustained publicity for *OK* helped stimulate the overall condom market, which grew from 19 million units in 1991 to over 23 million in 1993[5]. Other manufacturers and distributors began to notice the increased market potential and one of them, the London Rubber Co, launched a television campaign for *Durex* condoms in October 1993. In December 1993, just 2.5 years after the product's introduction, the condom project was completely graduated from USAID assistance.

Post Intervention Impact

The SOMARC intervention had a considerable impact on the condom market. *OK* remained the leading brand eight years after the graduation of the project. Its market share was approximately 52 percent as of late 2001. The next highest-selling brand was *Durex*, with 24 percent of the market, followed by *Eros* (10 percent) and *Amor* (9 percent). Other condom brands—such as *Lifestyles, Benetton, Fuji,* and *Sico* were introduced in Turkey, but none succeeded in capturing a significant share of the market. Consumer prices varied from US$0.21 to $0.54 per condom.

The marketing and promotion of *OK* condoms continued well beyond the end of the SOMARC program. The agreement between Eczacibasi and TFHPF was still in effect in late 2001 and Eczacibasi had increased the return-to-project fund by an additional 10 percent of sales revenues.

Figure 1:
OK Condom Sales 1991 to 2000



As a result of the combined efforts of Eczacibasi and the Durex Company, the condom market had been growing steadily and was estimated at 35 million units in 2001 - or 84 percent higher than in 1990. Condom availability

5 *Source: Zet Nielsen audit. September 1993*

also appeared to have increased in the previous 10 years. In addition to pharmacies, *OK* and *Durex* had succeeded in entering convenience stores and supermarket chains.

The *Durex* representative in Turkey credited SOMARC with helping to destigmatize condoms. The company welcomed the competition, (although *OK* probably captured some market share away from *Durex*) because it helped grow the overall market. *Durex* complemented these efforts with activities of its own, focusing on promoting the concept of safe sex in Turkish society. More recently, *Durex* had used its global survey on sexual behavior as a vehicle for press releases, interviews, and magazine articles. *Durex* appeared to have succeeded in combining business interests and public health goals, and public education was considered an integral part of the company's overall corporate objective. The level of *Durex* investments in Turkey was not known, but the fact that the company had created its own sales force in Turkey, rather than working through a distributor, reflected a strong commitment to this market.

With two fully sustainable brands situated at different price points in the market, a wide distribution network, and continued promotional activity, it is safe to conclude that the combination of social marketing programs and private sector investments contributed to the development of a healthy commercial market for condoms in Turkey. Although condom use by married women only increased by 1 percent between 1988 and 1998, the growth of the market suggests that condom use increased considerably in Turkey after the SOMARC intervention.

The Campaign for Low-Dose OCs

An advertisement for low-dose oral contraceptives appeared in Turkish physician and pharmacist journals.

In the late 1980's, 68 percent of all married women had concerns regarding OCs and only 9 percent were using them. The commercial sector supplied 80 percent of all OCs but overall sales were steadily eroding, partly as a result of a large influx of USAID-donated products in the public sector. The assessment conducted by SOMARC also attributed high discontinuation rates for this method to the dominance of high-dose pills on the commercial market.

The project partnered with three oral contraceptive manufacturers (Organon, Wyeth, and Schering) and developed an umbrella campaign designed to promote their low-dose OC brands: *Triquilar, Trinordiol, Microgynon, Desolet,* and *Lo-Ovral*. In contrast with Eczacibasi, OC manufacturers refused to invest a percentage of sales into the project, but agreed instead to contribute a percentage of the *increase* in OC sales. This agreement may have affected the long-term sustainability of the project, as the return-to-fund moneys generated by the pill program turned out to be much lower than for the condom program.

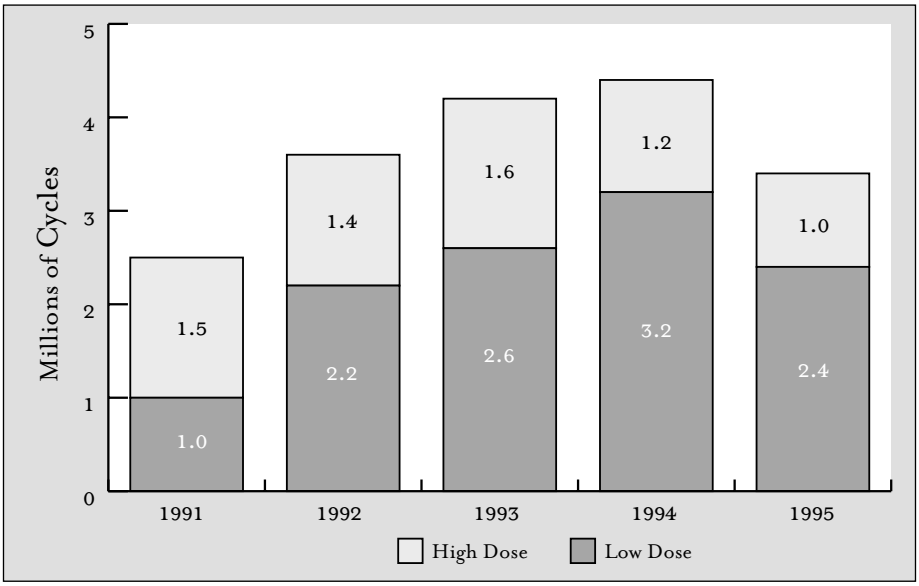
The OC project was designed to educate women about side effects and inform them of the availability of lower-dose pills in the private sector. The project speculated that switching consumers to low-dose pills would eventually result

in an overall increase of OC use. Promoting low-dose pills as a distinct product category also allowed the project to circumvent legal restrictions on brand advertising, which turned out to be the strongest motivator for private sector participation to this program. Direct consumer marketing consisted of a mass media campaign, low-literacy package inserts, and consumer brochures distributed through pharmacies nationwide. The campaign logo, which featured different phases of the moon, helped identify participating brands in commercial outlets.

The pricing of OCs (and all pharmaceutical products) was – and is still – controlled by the Turkish MOH, making most commercial pill brands affordable to a large proportion of consumers. In fact, the majority of Turkish pill users were already purchasing their pill products through the commercial sector. Price controls, however, also had the effect of making contraceptives relatively unprofitable for private sector companies, which would eventually affect these companies' willingness to invest in marketing and promotional activities.

Figure 2: Oral Contraceptive Sales 1991 to 1995 (thousand units)6

Figure 2:
Oral Contraceptive Sales 1991 to 1995[6]



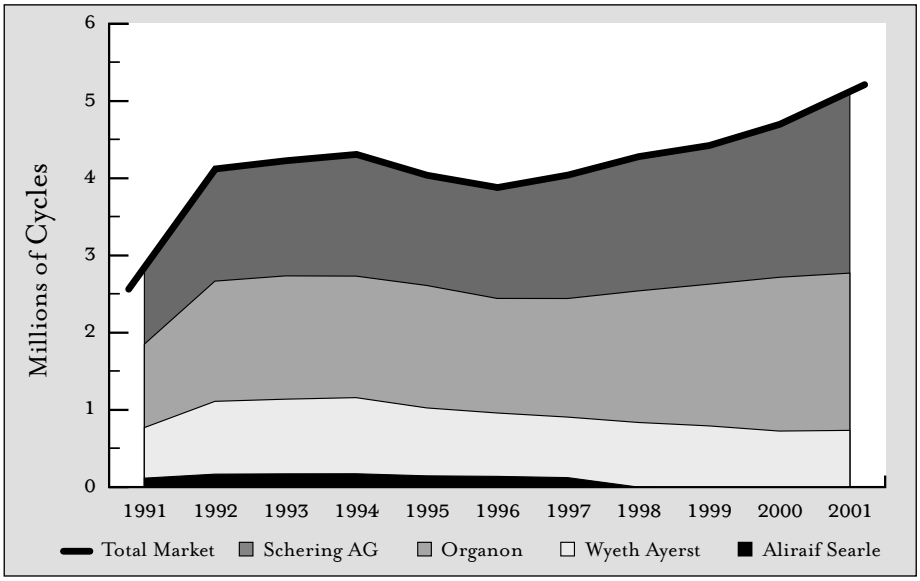
Key Results

The SOMARC campaign achieved its goals: by 1994 low-dose pill sales had increased 220 percent from 1991 and overall pill sales had increased 76 percent. A consumer tracking survey implemented in 1992 suggested that the project was effectively reaching its target market since 61% of the social marketing brand users were found to belong to the C and D socioeconomic groups. Total pill sales fell slightly in 1995 when the SOMARC program stopped providing advertising

6 Source: SOMARC, 1995

support, but the switch from high-dose to low dose pills proved to be permanent. In 2000, low-dose pills accounted for 82 percent of the market. These results also helped increase the interest of pill manufacturers in the Turkish market. Soon after the SOMARC intervention, Schering introduced a new low-dose product – *Ginera*. Wyeth and Organon followed suit with *Minulet* in 1994 and *Myralon* in 1995.

Figure 3:
Oral Contraceptive Sales 1991 to 2001[7]



Post Intervention Impact

In the years following the SOMARC program, pill sales continued to increase gradually. Total sales were expected to exceed 5 million units in 2001 – 13 percent higher than in 1995. Although it cannot be said that the SOMARC project had a drastic impact on overall pill sales in Turkey, it appears to have contributed to the reversal of the 10-year downward trend in private sector sales observed prior to 1991. Schering and Organon products accounted for most of the increase, whereas Wyeth sales had been slowly declining. Searle was no longer a player on the pill market at the close of 2001.

Overall use of OCs in Turkey actually decreased throughout the 1990s, and the SOMARC intervention may have contributed to a slowdown in this trend. The drop in pill use was 1.3 percent from 1988 to 1993, but only 0.5 percent from 1993 to 1998. In terms of supply sources, the private sector lost 9.3 percent of the pill market between 1988 and 1993 but only 1.8 percent in the next five years.

By the end of 2001, little institutional memory remained of earlier SOMARC activities among the pill manufacturers. Those who recalled the intervention had mixed feelings about it. While they generally supported public-private

7 *Source: IMS Health 1991-2001*

partnerships, they were also disappointed that the market had failed to grow more substantially. Some former SOMARC partners regretted the discontinuation of the pill program and subsequent efforts by the MOH and SOMARC to promote long-term methods. At least one manufacturer complained that the public sector was unfairly competing with the private sector by distributing free OCs in public clinics. All three pill makers felt that price controls and restrictions on brand advertising had prevented any sustained market development activity for OCs in the private sector.

Although investment in contraceptive products marketing was limited by late 2001, some pill makers had developed demand creation programs that attempted to circumvent restrictions on brand advertising. For example, one manufacturer had created clubs where pill users provided information and counseling to other women, creating a grass-roots program that relied exclusively on interpersonal communication. Generally, pill makers had adopted strategies that were consistent with their respective positions on the market. As the market leader, Schering was the most active company, investing in radio and TV spots, leaflets, and other communication material that promote OCs as a product category. This type of unbranded investment was considered productive by the company because any increase in demand would primarily benefit Schering products.

Another manufacturer, however, had essentially ceased to invest in contraceptive products and was now focusing on more profitable products such as hormonal replacement therapy and its leading product, an anti-depressant. As this manufacturer was not a leader on the OC market, any effort to increase its share would require considerable promotional investment. For example, intense detailing activities would be needed to break the monopoly that Organon was reported to have with gynecologists but the lack of profitability associated with contraceptives made them unlikely candidates for this type of investment.

The MOH's price setting policies at the end of 2001 appeared to be favorable to the introduction of newer, lower-dose products – particularly so-called third-generation pills such as *Harmonet* and *Minulet*. Because prices for these products are based on those found in European countries, where new products carry a higher margin, it was now possible for OC manufacturers to make more money as they introduced newer products.

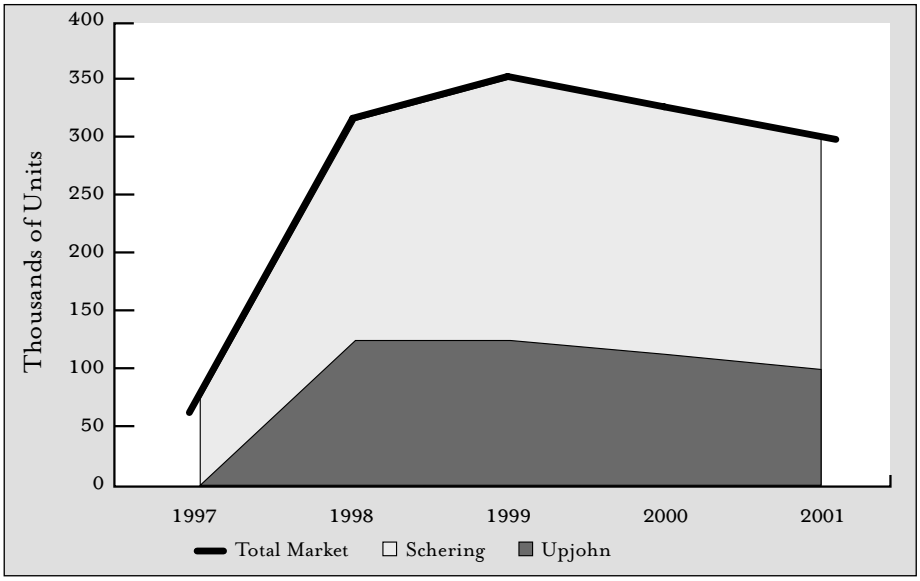
A brochure targeted towards providers describes the appropriate uses of Depo Provera.

Injectable Contraceptives

Depo-Provera had been introduced in the public sector in 1997 and supported by an intensive provider-training program. The MOH, however, had no plans to purchase injectables after the USAID-donated supply ended and the national strategy called for the private sector to provide 95 percent of injectables by the year 2000. Consequently, after the graduation of the OC and condom social marketing projects, SOMARC partnered with Schering, Pharmacia, and Eczacibasi to introduce injectables in the private sector.

Schering launched the monthly injectable *Mesygina* in 1997, and Pharmacia & Upjohn launched *Depo-Provera* a year later, with technical assistance from SOMARC and EngenderHealth. As in the OC intervention, the injectable launch relied on combined private and donor funding. SOMARC developed a three-week television campaign and public relations activities designed to address misinformation, concerns, and questions regarding this new method. Eczacibasi conducted special detailing and training programs for providers and pharmacists, provided product samples and brochures, and promoted a telephone hotline. Pharmacia and Schering also agreed to introduce injectable products in a consumer-friendly packaging that included user information and an injection card.

Figure 4:
Injectable Sales 1997 to 2001[8]



Key Results

Depo-Provera achieved annual sales of approximately 112,000 units in 1998, while *Mesygina* reached almost 190,000 units. Combined sales of injectables peaked at 350,000 units in 1999 but declined in subsequent years. The sales of *Depo-Provera* and *Mesygina* were deeply affected by high discontinuation rates. In spite of the project's provider training component, many women discovered the method through word of mouth and were able to obtain the product at most pharmacies without a prescription. In the absence of patient follow-up, these women often discontinued the method when they experienced side effects, such as amenorrhea or bleeding. Eczacibasi estimates that as many as 60 percent of users discontinued product use after one year. Studies showed, however, that the majority of those who discontinued injectables switched to another modern method rather than a traditional method[9].

8 *Source: IMS Health 1997-2001*

9 *Source: USAID Reproductive Health and Family Planning Assistance to Turkey 1990-2002, Successful Strategies.*

Post Intervention Impact

Regrettably, neither Pharmacia nor Schering succeeded in developing the injectable market. As a long-term method requiring the support of providers, injectables turned out to be much more difficult to market than OCs or condoms. The method faced strong resistance from providers, partly because they disliked having to manage its side effects, and partly because FP was not considered a profitable activity, compared to deliveries or abortions. Overcoming these barriers would have required sustained communication and training efforts, but budget constraints prevented injectable makers from developing such efforts beyond the SOMARC intervention. In particular, the substantial contribution of EngenderHealth to provider training and quality of care was no longer available after funding was phased out.

The low price of *Depo-Provera* turned out to be an obstacle to its sustained growth. The product was priced so as to make it affordable to low-income people, at the insistence of USAID and SOMARC. Yet, there is evidence that the market could have supported a higher price. Sales data suggest that 40 percent of injectable users opted for *Mesigyna*, which sold for the same price as *Depo-Provera* in 2001 (5 million Liras, approximately US$3.50). As a monthly injectable, *Mesygina* should have been perceived as much less affordable than *Depo-Provera*, but this did not seem to affect its market share. There is no doubt that the low retail price of *Depo-Provera* had an impact on Pharmacia's willingness to support the brand, as promotional investment is typically a function of sales revenue. This inability to generate revenue was worsened when injectables failed to reach high sales volumes quickly after their introduction on the market.

One industry executive referred to *Depo-Provera* as a "distracter", a product that effectively takes the company away from its core activities, which is to maximize the sales of high-margin products. Pharmacia maintained *Depo-Provera* on the market, however, because it belonged to a product franchise (a group of products for which there is enough business potential overall). For Pharmacia, this franchise is composed of all products related to women's health. Ironically, *Depo-Provera* may owe its presence on the Turkish market more to other, more profitable products in the company's portfolio, than to any specific demand creation efforts for the method.

In response to lagging demand, Pharmacia focused its marketing and communication efforts on provider detailing, shunning gynecologists for general practitioners who appeared to be more receptive to the method. Much attention was also given to nurses, particularly in health centers run by the MOH. Schering also adopted a similar strategy for *Mesygina*. This strategy suggests that injectable manufacturers relied in part on the public sector to help develop demand for *Depo-Provera*. Pharmacia also sold products to the MOH at the same price offered to private sector wholesalers. The proportion of *Depo-Provera* sales realized through the public sector, however, did not exceed 10 percent of total sales.

In retrospect, while this intervention justifiably focused a lot of its efforts on provider training and consumer communication, it may have been insufficiently funded to address the more complicated barriers facing injectables. As in the case of OCs, the phase-out of USAID funding left a void that private sector partners were ill equipped to fill. As a result, the achievements of the social marketing project where relatively short-lived, although injectables were still easily available in pharmacies at the time of the assessment.

The Private Provider Network Project (KAPS)

The Women's Health and Family Planning Service System (KAPS)[10] project coincided with rising concern for future contraceptive security in Turkey. Resource limitations and growing demand for healthcare services prompted the MOH to explore strategies that could shift a proportion of users to the private sector. The basic premise of the services marketing project developed by SOMARC was that the creation of a branded network would increase client flow and, in turn, lead providers to increase their capacity and willingness to provide such services to their clientele.

In 1994, SOMARC conducted an assessment of healthcare services in private facilities. The assessment revealed a strong and growing market, with 70 hospitals, 500 clinics, 3,000 pharmacies, 800 obstetricians/gynecologist, and 500 general practitioners in Istanbul alone.[11] The private sector was already serving many low-income consumers in C and D socioeconomic categories and had the reputation of providing higher quality care and shorter waiting times. FP services, however, were rarely offered in the private sector, even though women used private facilities for abortion, prenatal, delivery, and postpartum services.

At the request of USAID, SOMARC sought to capitalize on the existing healthcare infrastructure by encouraging private providers to form a network that would offer a comprehensive range of FP services. The objectives of the network were to raise the standards of practice in private sector facilities, address misconceptions about modern methods, and ensure that services were available at affordable prices. The physician network was launched on a pilot basis in two regions of Istanbul in October 1995 under the name KAPS.

To implement the multiple aspects of the program, SOMARC partnered with four organizations: TFHP (for marketing and communication), the Human Resource Development Foundation (for pharmacist training), EngenderHealth (for provider training in quality of care) and Marketing Systems (for provider training in services marketing). The network was marketed to consumers through a variety of communication and public relations activities, including an information hotline managed by TFHPF.

10 Acronym for Kadin Sagligi Ve Aile Planlamasi Hizmet Sistemi
11 State statistics Annual report. 1992

Accomplishments and Challenges

The network was successful in recruiting the participation of approximately 180 providers, including 130 private pharmacies and 50 private hospitals, clinics, and physician's offices. The biggest draw for providers turned out to be the right to use the KAPS logo, access to business and technical training, and the media exposure provided by the project. Participating physicians agreed to attend contraceptive technology and marketing training, adopt minimum quality standards and price caps for RH services, and submit to periodical visits by technical advisors. SOMARC and EngenderHealth collaborated to develop a common set of standards for RH/FP services and an assessment tool to monitor facilities throughout the network.

Services offered through KAPS were contraceptive counseling, low-dose oral contraceptives, IUDs, female and male sterilization, injectable contraceptives, and implant contraceptives. A client intercept survey conducted in April 1997 indicated that KAPS facilities clearly catered to SOMARC's low- to middle-income demographic target. The survey, however, detected no significant increase in client load or acceptance of FP. While outreach activities (such as mass media, coupons, etc.) contributed to increased awareness of the FP services available at KAPS, this awareness did not translate into usage. A second survey conducted the following spring revealed that in most cases providers still failed to initiate discussion about contraception[12].

The KAPS logo used to identify network participants.

In response to research findings, SOMARC adapted its strategy to emphasize internal rather than external interventions. In the summer of 1997, SOMARC began to train providers in post-abortion counseling to ensure that all women undergoing an abortion at KAPS facilities received FP counseling and were offered contraceptive protection. One-on-one training and follow-ups were provided to KAPS members that stressed the need for FP promotion at all stages of the abortion process. A third and final client intercept study conducted after the post-abortion intervention clearly underscored its impact: The number of abortion clients who had received FP counseling had more than doubled over previous rounds, and nearly one third had adopted a family planning method as a result of counseling. It appeared that the project had successfully tapped into potential demand among post abortion clients.

Post Intervention Impact

Although KAPS succeeded in recruiting 180 members into the network, its impact on service provision was difficult to measure and funding ran out before SOMARC could find ways to make the program sustainable. There was a feeling among former members of the network who were interviewed by the CMS team that, given more time and funding, the project might have had a lasting impact on the provision of FP services. Certain aspects of the project were popular among members, such as technical assistance in quality of care

12 Source: SOMARC III Completion Report. October 1992-1998. The Futures Group

and the promotion hotline (by the end of 1996, the hotline had received over 10,000 calls). What failed to materialize, according to former members, was the expected increase in clientele.

Other problems plagued the KAPS project, which might have been resolved given more time. Member providers complained that they were not being consulted in decision-making, particularly those relating to network promotion. There was also the perception that better cohesion between the different partners and coordination with the Turkish Medical Association might have gone a long way towards sustaining activities beyond the life of the project.

Nevertheless, the KAPS project provided a better understanding of service providers and helped improve subsequent efforts to enroll the support of providers, particularly in creating demand for long-term methods. Provider networks were not common in the context of social marketing before this intervention. It is to SOMARC's credit to have innovated in this respect and chosen to document lessons learned for the benefit of future projects.

Lessons Learned and Conclusions

All four social marketing interventions in Turkey were designed with graduation as a key objective. These projects had relatively short-term goals, such as product availability, increased sales and private sector ownership. Programmatic longevity was not emphasized in the project design, nor were there specific deliverables related to building mechanisms for sustaining program activities. Consequently, it would be unfair to evaluate the SOMARC project based on criteria that were not included in the initial project design. Nevertheless, there are important lessons learned in these interventions regarding long-term project impact, particularly in the context of contraceptive security.

The long-term impact of partnerships with the private sector is largely determined by their compatibility with the goals of partnering organizations

The condom social marketing project appears to have had a longer-lasting impact on supply and demand than the oral and injectable programs did. Much of the success of the project can be attributed to the synergy between Eczacibasi's sales and marketing capacity, and the TFHP's lobbying and communication skills. In addition, the TFHP played a big role in convincing Eczacibasi to continue marketing activities for *OK* condoms beyond the duration of the SOMARC intervention. The fact that key Eczacibasi executives were members of the Foundation's board of directors helped sustain the distributor's commitment to the condom social marketing program. This relationship between a local non-profit organization and a commercial company constitutes a model for other partnerships the private sector.

Another key aspect of the condom project was the fact that the commercial partner (Ezcacebasi) had considerable influence on the project's design. In fact, the company made in clear that it would not participate in the project unless it retained control of the marketing strategy, including the pricing of the condom brand. In other words, Ezcacibasi wanted to "do it their way," much to the frustration of SOMARC and USAID. The long-term success of this project underscores the benefits of allowing commercial partners to play a leading role at both the strategic and implementation levels.

Although the private sector companies that participated in the OC and injectable projects appear to have shown substantial commitment to social marketing goals, this commitment was dependent on continued funding through the SOMARC project. Once funding was phased out, these companies reverted to corporate strategies that tended to allocate marketing funds according to a product's profit margin. It is also worth noting that the OC market was more fiercely competitive than the condom market. As a result, the cooperation that was created between the three makers of OCs was unlikely to survive beyond the life of the USAID-funded project. The combination of low profit margins and a loose partner coalition driven primarily by non-commercial entities explains the lack of subsequent involvement by these companies.

The SOMARC experience in Turkey highlights the need to ensure that local partners have a stake – financial or otherwise – in sustaining social marketing activities beyond the life of the donor-funded project. Non-profit private organizations have a role to play in encouraging commercial partners to live up to their commitment and publicizing their contribution to the public good – an endeavor in which TFHPF excelled.

Using FP services to increase client volume at private sector facilities is unlikely to be effective unless significant potential demand exists for these services.

In 1998, the SOMARC project documented lessons learned in the KAPS program in an evaluation report[13] based on a survey of network members. Key findings were that awareness of the availability of FP services in the private sector did not translate into increased demand for those services and had no significant impact on client volume or the profile or services delivered. Focused inreach promotion during abortion-related visits, however, had a significant impact on FP counseling and service delivery.

The providers interviewed in Istanbul by the POPTECH team, and later by CMS, recommended narrowing the scope of the network's activities to post-abortion and postpartum counseling. This suggests that provider networks might be most effective if they applied the same targeting principle that rule consumer goods marketing. According to this principle, focusing marketing activities on those most likely to have a perceived need for the service works better than attempting to target the population at large. The KAPS network could have focused on delivery, postpartum, and abortion patients from the onset of the campaign, freeing-up some resources that were invested in mass media advertising in hopes of reaching a large audience.

One question raised by the CMS assessment team was whether promoting FP services was enough to attract women to the private sector in the first place. Some respondents suggested that while the provider network concept could go a long way towards increasing the use of private sector facilities, it should have been applied to primary care services, not FP. A similar recommendation was made in the 1998 POPTECH evaluation report[14].

Another tactic could have been to focus on primary care services and promote the competitive advantages of the private sector in this field (better service, short waiting time, friendly care, etc.). As women exposed to the campaign began to use primary care services, they could have been introduced to FP counseling as a bundled service. It appears that the KAPS project overestimated the demand for FP and its ability to increase overall client load.

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13 Evaluation of the KAPS Programme in Turkey, A Qualitative Study Among KAPS Members, The Futures Group International, Istanbul, September 1998

14 The team believed that the Istanbul KAPS model would "never be sustainable or replicable", but that individual hospitals and clinics could become self-sustaining if they "bundled" family planning with other services.

Creating long-term demand for new methods requires sustained marketing efforts focusing on both consumers and providers.

Another key lesson of the KAPS project was that marketing new contraceptive methods, especially those requiring provider services, such as injectables, is more complicated and costly than marketing products over the counter. In addition to convincing consumers to use the new method, the project must market them to providers and sustain their interest in the method over the long-term. The time and funding imparted to the project appear to have been insufficient to achieve this goal.

Injectables as a new FP method did not benefit from substantial demand among users and could count on limited support from the provider community. Therefore this method would have greatly benefited in the long term from a motivated and easily identified provider base such as the KAPS network. Unfortunately, the phase-out of donor funding for the network diminished prospects for injectables as well. While manufacturers continued to invest in provider training and detailing after the end of the SOMARC program, they were unable to sustain the intensive investment needed to build support for this method among private sector providers.

SOMARC's experience with injectables in Turkey also highlights the fact that low-prices need not be the primary goal when introducing new FP methods. If there is little or no demand for a new product, generating awareness and provider support is likely to be the main goal, which calls for substantial investment in demand creation activities. The only way to support these activities is through donor funding or sales revenue. If donor funding is limited and sales volume is low then prices may need to remain high, at least for some time.

Unfavorable policies toward the private sector can undermine the longevity of social marketing partnerships. This is especially true for pharmaceutical products.

Corporate strategies are greatly influenced by government policies, especially price controls. The communication campaign for low-dose OCs developed by SOMARC had the effect of promoting products that generated the lowest margins for manufacturers. These low margins were the result of price legislation that imposed the lowest price ceilings on low-dose pills, while higher-dose pills could retail for a higher price. It is to SOMARC's credit that pharmaceutical partners agreed to participate in a program that was contrary to their commercial interest. No effort, however, was undertaken to redress the pricing imbalance between low-dose and high-dose products. Such an attempt might have had a substantial impact on corporate priorities, as evidenced by the current investment on third generation pills.

Another government policy that may have had an impact on private sector sales, according to private sector representatives, is the free distribution of contraceptives in public sector facilities. This practice would have had a more noticeable impact on OCs than on condoms as the MOH caters primarily to married women, the primary users of OCs. Indeed, the increase in women seeking contraceptives in the public sector was much higher for pill users.

Contraceptive products sold in the private sector were not equally affected by these policies. For example, while condoms could be priced according to supply and demand, OCs and injectables were subject to strict government oversight. The pricing of condoms appears to have followed clear market segmentation patterns that suggested three price points for which demand could be expected: low, medium, and high. The bulk of the business, however, was realized by the high and medium-priced brands – *Durex* and *OK*. In the case of oral and injectable contraceptives, prices were determined by arbitrary regulations rather than by market forces. This appears to have had a negative effect on demand creation efforts, which are largely determined by the margins afforded on products.

Price controls were also partly responsible for the absence of *Norplant* from the Turkish market. Although the introduction of the method in public sector facilities during a pilot phase had proved successful, the method was never introduced on a national basis. The makers of *Norplant* cited high production cost and low-profit margins as reasons for not registering the product in Turkey.

The sustainability of social marketing programs based on commercial partnerships is largely determined by the ability of these programs to influence market dynamics in a durable way. If obstacles to market growth can by addressed by using classic marketing tactics – such as intensive mass media communication and improved distribution – a social marketing program may have the effect of jump-starting private sector activity, as it did in the case of condoms. If, on the other hand, regulatory obstacles discourage long-term investment, it may be necessary to include policy-related activities in social marketing programs to sustain their impact.

Partnerships with the private sector can help increase contraceptive security; this role can be maximized by better coordination between social marketing and policy activities.

Contraceptive self-reliance – or contraceptive security as it is commonly referred to today – had not yet become a priority in the early 1990s, when the SOMARC project was in full swing. Social marketing programs aimed to increase the availability of contraceptives at affordable prices and supplement the demand creation efforts by private sector suppliers. They did not, however, attempt to address contraceptive supply in its broader context, as defined by the combined activities of the public, private, and NGO sectors. Similarly, the POLICY project was not expected to coordinate activities with SOMARC

because its mandate did not include deliverables within the private sector. Finally, the two projects were not concurrent, but started and ended at different times. Nevertheless, the 2002 USAID final report indicated that contraceptive self-reliance was an expected outcome of the SOMARC program:

> "…While the POLICY Project led the effort of working with the public sector organizations in important aspects such as awareness raising, policy analysis, and policy dialogue, SOMARC worked towards leveraging resources within the private sector to complement the CSR initiative.[15]"

One of the lessons learned in Turkey is that public/private workshops do not automatically result in noticeably increased private sector activity. A follow-up activity to the workshops might have included specific interventions designed to foster coordination between the activities of the two sectors. This cooperation could have been achieved through improved interaction between projects that dealt primarily with the MOH and those that focused on the private sector. Alternatively, the social marketing effort might have included a policy component that monitored and promoted coordination with the MOH. It is conceivable, therefore, that both social marketing and policy interventions could have played an even bigger role in Turkey's contraceptive self-reliance effort.

15 Reproductive Health and Family Planning Assistance to Turkey, 1990–2002, Successful Strategies, the Agency for International Development, February 2002.

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